MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, April 22, 2004
10:09 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
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CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Dual eligible beneficiaries -- Anne Mutti, Susanne Seagrave, Sarah Lowery

MS. MUTTI: This presentation will focus on several new analyses that we've done on dual eligibles. This complements the work that we've done earlier and will be part of a chapter, a draft of which you've received. We're adding these new analyses. One will be more detailed findings on the composition of the dual population and their spending patterns. Another one that Susanne will present on is how long have duals been duals. And a third one is our analysis of dual beneficiaries' access to care. While Dan is not initially presenting any information here he is available to answer questions because he did much of the work on the spending and composition of the dual population. In the future we hope to follow up on this work, looking particularly at the quality of care for dual beneficiaries. I know that was an interest of at least one member of the commission. We'd also like to look at policy options to improve their access and quality and cost-effectiveness of their care. At the end of the presentation we look forward to hearing your comments not only on this material which we plan to incorporate in the chapter but also the whole chapter altogether.

As we discussed last month the dual population is not demographically homogenous, nor is it all equally costly to the Medicare program. As with non-dual spending, it's concentrated in a minority of beneficiaries. To get an understanding of the composition and the spending patterns of the population we divided the population into six subgroups, three under disabled and the same three categories under aged. We also aggregated the three categories for disabled as well as aged so you actually see eight lines of data there. Let me give credit, this work builds on stuff that Chris Hogan and Sandy Foot has done with respect to the disabled population.

A couple words about our method. First we pulled MCBS data over two sets of three years. This was to allow a sufficient sample for us to cut it as finely as this analysis required. Then we aside the beneficiaries to categories using a hierarchy. So that if people had mental or cognitive problems they were assigned to the mental and cognitive subgroups regardless of whether they had difficulties with ADLs. So some of those people in the mental and cognitive category definitely have problems with activities of daily living. For those people assigned to the other categories, they do not have mental or cognitive problems as we measured it.

We identified people with mental and cognitive problems through a combination of survey responses, diagnosis information on claims, and prescription drug use. We sought to count only those who have serious mental illness including dementia and mental retardation. We did not try to capture people with depression only in this analysis. When assigning beneficiaries to a category based on limitations in activities of daily living

we used survey results only.

As with our earlier analysis we found that just over one-third of the duals are disabled and under 65; about two-thirds are aged. Of the disabled, about half have mental or cognitive problems. Of the aged, about one-third have mental and cognitive problems. Perhaps surprisingly, just less than half of the aged duals have difficulty with less than two ADLs. The composition of duals has changed somewhat over the last few years. The proportion of duals under 65 and disabled has increased from 28 percent to 34 percent. This appears roughly commensurate with the increase in the population of disabled overall in the Medicare population. There's also been a small increase in the portion of duals, aged and disabled combined, that are mentally and cognitively disabled.

By looking at aged and disabled dual beneficiaries together we can summarize our findings in another way; 39 percent have mental or cognitive limitations, 20 percent have difficult with two or more ADLs but do not have cognitive or mental problems, and over 40 percent have difficulty with less than two ADLs, but again, don't have mental or cognitive problems.

On this slide we look at Medicare spending levels by subgroup and compare them to non-duals with the same characters in the 1999-2001 time period. It is important to focus on the fact that here we're just presenting the Medicare spending totals, not total spending for the beneficiaries which would also include Medicaid spending and out-of-pocket spending. We find that the most costly group of duals here is the aged with mental and cognitive limitations, and then next comes the age with difficulties with two or more ADLs. The disabled overall are less costly to Medicare than the aged. And certainly the least costly groups are those with difficulties with less than two ADLs.

When comparing Medicare spending for duals to non-duals, the disabled are statistically significantly different than their non-dual counterparts. However, Medicare spending on aged duals is not statistically significantly different than spending for non-duals in any of those subgroups, and the asterisks indicate the statistical significance on the slide there.

The similarity in Medicare spending for aged duals and non-duals should not mask the differences in total cost between the two populations however because the aged duals are more likely to be in nursing homes than aged non-duals, much of their spending is reflected in Medicaid spending and that's just not shown here.

We also took a look at how Medicare spending is distributed by service for duals compared to non-duals. For this analysis we just looked at those living in the community. On this chart the numbers reflect the percent of Medicare spending on each of the selected service. As you can see, the bulk of spending for both duals and non-duals is for hospital inpatient and physician care. I don't think that's very surprising. But we do see a few statistically significant differences between the two groups, as indicated by the asterisks.

First, a greater proportionate of Medicare spending is devoted to home health care for duals than non-duals. And

second, a great portion of spending is devoted to both physician and SNF care for non-duals as compared to duals.

This chart builds on the last one by adding two columns with data from the 1993 to 1995 period. This comparison allows assess us to see if there's been a change in spending patterns, and if there has been, is it consistent across both duals and non-duals, or does it just apply to one group. The asterisks here indicate statistically significant differences across the time period. So we can see for non-duals, the portion devoted to each service category changed. The portion spent on hospital and home health care declined, while the portion spent on physician, OPD, and SNF care went up.

Just to be sure you're following me here, for example, on hospital care in the '93 to '95 period, the non-duals hospital care had a portion of about 52.2 percent of their total Medicare spending. By '99 to '01 it declined to 49.1 percent. Spending for duals changed also. As with non-duals, there was a decline in the portion spent on home health and in increase in the portion spent on physician and OPD care. There was no statistically significant change in the portion spent on SNF or inpatient care.

With that, let me turn it over to Susanne.

DR. SEAGRAVE: In response to a question from the Commission we analyzed the length of time dual eligible beneficiaries tend to remain on Medicaid. It is important for policymakers to understand the length of time beneficiaries remain on Medicaid because it affects whether, and if so how, they might want to consider tailoring policies such as policies that encourage care management to this particular population. A couple of caveats to note about this data. First, the data likely under-represents the medically needy dual eligibles as these beneficiaries are much more difficult to identify in administrative data. The other thing to note is that we included beneficiaries who had gaps in their Medicaid coverage in this, because the question that we were interested in looking at was how long in total people tended to remain on care. But the people who had gaps were in the minority in this data.

We found that dually eligible beneficiaries tended to remain on Medicaid for relatively long periods of time. This chart include Medicare beneficiaries who first became eligible for Medicaid in 1994, 1995 or 1996, and we have data on these people through 2002. The total height of the first bar represents those people on Medicaid for less than or equal to one year. The second bar represents those on Medicaid for between one and two years and so on. The yellow sections on the top of the bars indicates the percentage of these beneficiaries who died in each of the time periods.

As you can see from the bar on the far right, a full 47 percent of these beneficiaries stayed on Medicaid for six to nine years, or through the end of 2002. I should note that some of these beneficiaries could have kept going on Medicaid past the period we were able to observe.

Conversely, only about 14 percent of these beneficiaries are in the bar on the far left, indicating that they were on Medicaid

for one year or less. Of this 14 percent, about 40 percent of those died in the first year.

This analysis suggests that policymakers should keep in mind that dual eligibles tend to stay on Medicaid for relatively long periods of time, when designing policies targeted to this population. For example, these results may make care management options more meaningful for this population.

Sarah Lowery will now discuss our findings regarding duals' access to care.

MS. LOWERY: Are dual eligibles able to access to health care they need? This question is particularly relevant for this population because, one, they exhibit characteristics associated with needing care, like they have limitations in activity of daily living, as well as they rate their health status poorly. And two, they often have characteristics that may hinder their ability to obtain care; for example, they are often poor and poorly educated.

One way to measure beneficiaries' access to care is by asking beneficiaries themselves to rate their access to care. Two surveys that do this are the CAHPS, the Consumer Assessment of Health Plan Survey, and the MCBS, both of which are administered by CMS. Results from these surveys in 2001 show that most duals report good access to health care. Of the questions that we analyzed, between 75 percent and 93 percent of dual eligible beneficiaries highly rate their access to care.

Medicare beneficiaries with other sources of supplemental coverage, such as employer-sponsored coverage or Medigap, rate their access to care more highly than duals however. The exception to this is beneficiaries with other sources of public supplemental insurance, such as that from the Department of Veterans Affairs. These beneficiaries do not rate their care as statistically different than duals.

Beneficiaries without supplemental insurance, those with just Medicare. defined as Medicare-only beneficiaries, may or may not report better access to care than dual eligibles. Results depend on the access of care that is measured.

Now we'll look at these measures.

When asked if they had a usual source of care like a particular clinic, doctor, or nurse duals respond yes more often than Medicare-only beneficiaries. Duals access to personal doctors, nurses, or facilities appears to be good. Duals also report that they delay care due to cost less often than Medicare-only beneficiaries. Intuitively, this make sense since duals have little out-of-pocket liability. The majority have Medicaid coverage for services that Medicare does not cover and for cost-sharing associated with Medicare-covered benefits.

In response to questions asking how often they got immediate care when needed or got a prompt routine health care appointment, Medicare-only beneficiaries responded usually or always more often than duals. This suggests that duals may have slightly more problems accessing both immediate and routine care than do beneficiaries with only Medicare. These differences are statistically significant but are not very great, as you can see from the slide.

When asked the broad, overarching question of whether the beneficiary had any problem getting necessary care we find conflicting results. This question to asked on both surveys and on the MCBS we find no difference between duals and Medicare-only beneficiaries responses. However, on CAHPS duals report that they have slightly more problems getting necessary health care than Medicare-only beneficiaries. Both duals and Medicare-only beneficiaries appear able to see a specialist when needed and both groups appear satisfied with their personal doctor, specialist and overall health care.

So overall when compared with Medicare-only beneficiaries duals have a slightly more difficult time accessing immediate and regular care, but they are more likely to have a usual source of care and less likely to delay care due to cost. Again, these differences are statistically significant but are generally small. Both groups rate their health care and providers highly.

It's important to keep in mind that both MCBS and CAHPS are beneficiary satisfaction surveys, which can be biased and influenced by factors such as socioeconomic status and education levels. For example, one bias that can affect survey responses is the tendency of respondents to answer in a way that they perceive to be consistent with societal norms rather than based on their own personal experience. Studies have shown that survey participants with lower income or education levels exhibit biases such as this, and therefore these demographic groups satisfaction with their access to health care may be overestimated. It is important to keep this in mind for duals in particular because they are poorer by definition and may often have lower education levels.

Another limitation of only analyzing survey data to determine whether beneficiaries have good access to health care is that these datasets are unable to describe whether beneficiaries received appropriate health care. We plan to look into this further, together with our work on quality.

Now we welcome your comments on this presentation and the draft chapter.

MR. HACKBARTH: Any questions or comments?

DR. REISCHAUER: The first few pages where you are trying to lay out who's eligible for what I thought I understood until I read this. It's even more complicated than I thought, and I think you made it even more complicated than I now think it is, in the sense that what most people are interested in is the what, and then the who. By the what, they're the full dual eligibles, and there are a required budget and then there's an optional bunch. I don't know if the people between 73 percent and 100 percent of poverty which at state option can receive full dual, whether the state without a waiver can offer a more limited benefit package for those folks than to others. I don't think so. I know the medically needy they can, but I don't think they can for them.

But you make it sound like these guys are really QMBs that some states are deciding to give something else to, whereas, there's the required dual eligible folks, 73 percent of poverty and below, states have the option to expand that up to 100

percent of poverty and a number of states have. Then there's the QMBs, which federal law requires everybody below 100 percent to get it, and the SLIMBs, et cetera. I have a suggestion for maybe how to arrange the chart, if you think it makes sense.

I then had a question about the mental health payment rates. This is on page 24. In scenario A, is it true that if the Medicaid rate is $50, Medicaid has to pay $12.50, but if the Medicaid payment rate is $49.99 it pays zero? Because I thought Medicaid didn't have to pay anything over it's own payment rate.

MS. MUTTI: Actually let me spend a moment thinking about that and I'll clarify that.

DR. WAKEFIELD: Is the PACE program just for dual eligibles or were you just taking about it when it's applied to dual eligibles? I couldn't tell. It's discussed on page 32.

MS. THOMAS: In order to participate in PACE you have to be Medicare or Medicaid. You don't have to be both but most people are, and there are processes to get capitation payments from each program. But if you're only Medicare, of course there's only a Medicare. If you're only Medicaid, there's only Medicaid. But typically, 95 percent of the folks in PACE are dual.

DR. REISCHAUER: In that complex chart, table two, under the ADLs the dual thing doesn't add to 100.

MS. MUTTI: I caught today too. It's supposed to be 45 percent on the first one.

DR. REISCHAUER: Then I would, the first time you mention the word Medicaid I would put parentheses or a comma, means-tested program. It isn't till about page seven that you say that, and I think it brings more understanding to some of the things you're saying about income levels and other things early on.

MR. HACKBARTH: Thanks.